STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 100833-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 3rd day of December 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 16, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On October 23, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be resolved by analyzing the Blue Care Network (BCN) BCN 10 certificate of coverage (the certificate) and its related BCN Healthy Living Rider (the rider). It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
BACKGROUND

The Petitioner enrolled for group health care benefits with BCN effective June 1, 2007, and was also conditionally enrolled for 90 days in BCN's Healthy Blue Living (HBL) program which is described in the HBL rider as

> the BCN coverage program designed to promote or maintain good health and/or prevent disease or the progression of disease for Members in the Program. The Program rewards Members that maintain or adopt healthier behaviors by making lower copayments, and/or coinsurance and deductibles available to those Members.

In order to continue to receive the HBL (or "enhanced") program benefits beyond the 90 days, the Petitioner was required to submit certain documentation about his health status and life style behaviors. According to BCN, that documentation was not submitted by August 31, 2007, and so the Petitioner was moved to the "standard benefits" program effective November 1, 2007.[1] He remained in the standard benefits program until November 30, 2007, when he went on leave from work and was out of the country and his coverage with BCN was suspended.

The Petitioner returned in April 2008 and his coverage was reactivated effective May 1, 2008, at the standard benefits level. On May 27, 2008, he had surgery. When the claims for that surgery were processed at the standard benefits level and not the HBL or enhanced level, the Petitioner appealed. The Petitioner exhausted BCN's internal grievance process and received its final adverse determination letter dated September 30, 2008.

III
ISSUE

Did BCN properly deny the Petitioner continued coverage in the Healthy Blue Living program?

IV
ANALYSIS

Petitioner's Argument

The Petitioner believes his surgery in May 2008 should be covered at the HBL enhanced level, which he says is the coverage he signed up for when he enrolled in May 2007. In a letter

[1] The Petitioner was given an additional 60-day grace period (until October 31, 2007) in which to meet the requirements to remain in the HBL enhanced plan but did not submit the documentation by that date, either.

dated October 6, 2008, that accompanied his request for external review, the Petitioner said:

> My policy with BCN cancelled sometime in December 2007 because of non-payment which is ok for them to cancel it since I was not using it and I already knew that it will start back when I return back to work.
>
> I never received any mail from BCN to sign a HBL form prior to my departure overseas on my sabbatical leave, like they claim.
>
> When I returned back from my sabbatical leave, BCN did not properly communicate to me what is happening with my policy and put me in a different plan that is not the plan that I signed up for in May 2007 during open enrollment.
>
> I was a victim of improper communication. They never informed me that my new plan that started back automatically…upon my return to work is different from what I signed up for in May 2007.
>
> The nurse at my specialist['s] office…who performed the surgery told me that I will be covered 100% because I got the referral from my PCP [primary care physician]…and I do not have to pay a penny.
>
> I made sure and confirmed with my PCP that there will be no out of pocket expenses since this surgery was being performed by a specialist that he referred me to him [*sic*].

The Petitioner says his surgery left him responsible for $1,018.88 in out-of-pocket expenses. He believes his benefits should be restored to the HBL enhanced level and his surgery should be covered at 100%.

Respondent's Argument

BCN says it mailed the Petitioner an enrollment kit on May 16, 2007, that explained the HBL enhanced program requirements. It says it also sent him a reminder in August 2007 that documentation was due.

In its final adverse determination, BCN explained why the Petitioner was placed in the standard benefits program after being in the enhanced benefits program:

> The required documentation to remain in the enhanced benefit level was not submitted within the required time period. We did not receive your and your spouse's Health Qualification Form (HQF) and Health Risk Appraisal (HRA) in the approved enrollment time period which ended August 31, 200[7]. Therefore, we have maintained our decision and your

> contract will remain in the standard benefit level. You may re-apply for our enhanced benefit at your next open enrollment.

BCN contends that changing Petitioner's coverage to the standard benefits plan is consistent with the terms and conditions of the rider.

Commissioner's Review

Health maintenance organizations are permitted under MCL 500.3426 to offer wellness programs like the BCN HBL program in this case that provide for reduced copayments, coinsurance, or deductibles if conditions are met. To remain in the HBL enhanced benefit plan beyond the initial 90 day period, eligible members must meet the requirements of the rider. The rider includes the following provisions:

> **HOW TO EARN THE HEALTHY LIVING ENHANCED BENEFITS IN THE FIRST YEAR OF ENROLLMENT**
>
> Upon enrollment each Healthy Living Eligible Member will receive Enhanced Benefits for a 90-day period. To continue receiving the Enhanced Benefits each Healthy Living Eligible Member must take the following steps:
>
> 1. Within 90 days of enrollment each Healthy Living Eligible Member must complete a Health Risk Assessment (HRA) and a Healthy Living Enrollment form which will assess the Member's medical condition and/or lifestyle behavior in relation to the following areas:
>
>   - Blood pressure
>   - Smoking
>   - Cholesterol
>   - Blood sugar
>   - Weight
>   - Alcohol use
>
> 2. In order to earn the Enhanced Benefits, Healthy Living Eligible Members must achieve a score of 80 points or more on the Healthy Living Enrollment Form. Scores are based upon a combined assessment of the Member's current medical condition and/or lifestyle behavior and the Member's commitment to comply with the conditions of programs and behaviors recommended by their primary care physician and BCN. The results of the Healthy Living Enrollment Form must be reviewed with and signed by the Member's primary care physician. The results must be submitted to BCN within the 90-day time period.

> 3. If both Healthy Living Eligible Members have Healthy Living scores of 80 points or more as a result of their current medical conditions and/or lifestyle behaviors, all members on the contract will automatically continue to receive Enhanced Benefits until the date for Reassessment recommended by the Members' primary care physicians.
>
> * * *
>
> 5. At the time of the Member's Reassessment, the Member must evidence to the Member's primary care physician that he or she has maintained or achieved a Healthy Living score of 80 points in order for the entire contract to qualify for Enhanced Benefits.

The Petitioner was required to have the Health Qualification Form (HQF) and Health Risk Appraisal (HRA) submitted by October 31, 2007,[2] in order to continue in the HBL enhanced program. When BCN did not receive the Petitioner's completed forms, it says it sent him a reminder that he needed to get them submitted; and warned that he would be moved to the standard benefits plan if he did not do so within the required time period.

The Petitioner contends he did not receive any communication from BCN about the HBL program when he returned to work in May 2008. However, he had already been moved to the standard benefits program in November 2007 before he went on leave and left the country and would not have received any additional information when he returned.

The Commissioner is sympathetic to the Petitioner's plight but is unable to order the remedy he seeks. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether BCN properly administered benefits under the terms and conditions of the Petitioner's certificate, its riders, and state law. BCN says that the Petitioner did not submit the documentation needed to continue in the HBL enhanced benefits program and the Petitioner tacitly concedes that he did not submit the documentation (although he blames miscommunication). Under those facts, the Commissioner finds that BCN was correct in changing the Petitioner's coverage from the HBL enhanced to the standard benefits program

[2] Because of the 60-day grace period, the Petitioner had until October 31, 2007, to meet requirements.

and required by the rider. Therefore, claims for the Petitioner's surgery on May 27, 2008, were correctly processed at the standard benefits level.

V
ORDER

The Commissioner upholds BCN's September 30, 2008, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.